TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Fort Worth

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-16-3230-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Regardless of the billed charges on the line for the OR service, payments are still allowed for the services per rule 134.403 section E… Based on their payment of $12,684.03 for the APC a supplemental payment is still due of $322.14 on the APC alone, at this time."

Amount in Dispute: $395.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain the requestor, Texas Health Fort Worth is not entitled to additional reimbursement for date of service 12/23/15 in the amount of $322.13 based on DWC adopted medical outpatient hospital fee guidelines, Medicare payment policies and correct coding initiative (CCI) edits in effect at the time services were provided."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 23, 2015	29888, 64450	$322.13	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00 – CCI edit reviewed and suppressed
   - P12 – Workers' Compensation State Fee Schedule Adj
   - RD7 – Multiple Procedure/1st Procedure
   - RD8 – Multiple Procedure/2nd Procedure (50%)
   - 59 – Allowance based on Multiple Surgery Guidelines
   - W3 – Appeal/reconsideration

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are:

1. **How the payment rates are set –** found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf, which states,
   To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.hhs.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.hhs.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum B. These files are updated quarterly.
4. **Discounting** - Multiple surgical procedures furnished during the same operative session are discounted. The full amount is paid for the surgical procedure with the highest weight; Fifty percent is paid for any other surgical procedure(s) performed at the same time.
5. **Outliers** - The OPPS determines eligibility for outliers using either a "multiple" threshold, which is the product of a multiplier and the APC payment rate, or a combination of a multiple and fixed-dollar threshold. A service or group of services becomes eligible for outlier payments when the cost of the service or group of services estimated using the hospital's most recent overall cost-to-charge ratio (CCR) separately exceeds each relevant threshold. The outlier payment is a percentage of the difference between the cost estimate and the multiple threshold. The CMS OPPS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under "Annual Policy Files" includes a table depicting the specific hospital and CMHC outlier thresholds and the payment percentages in place for each year of the OPPS.

Issues

1. What is the applicable rule pertaining to calculation of fee schedule amounts?
2. Is the requestor's position statement supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment" and W3 – "Additional payment made on appeal/reconsideration." 28 Texas Administrative Code §134.403(f) states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

Based on the APC of the remaining services in dispute, the MAR is calculated below:

Submitted code	Status Indicator	Multiple Procedure Discounting	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
29888	T	Yes this procedure paid at 100%	0052	$6,322.79	$6,322.79 x 60% = $3,793.67	$3,793.67 x 0.9512= $3,608.54	$6,322.79 x 40% = $2,529.12	$3,608.54 + $2,529.12 = $6,137.66	$6,137.66 x 200% = $12,275.32
64450	T	Yes this procedure is paid at 50%	0206	$372.76 ÷ 50% = $186.38	$186.38 x 60% = $111.83	$111.83 x 0.9512 = $106.37	$186.38 x 40% = $74.55	$106.37 + $74.55 = $180.92	$180.92 x 200% = $361.84
								Total	12,637.16

2. The requestor stated in their position statement, "Regardless of the billed charges on the line for the OR service, payments are still allowed for the services per rule 134.403 section E…" Review of the submitted medical claim finds no amount in Line 16, Box 47 of the UB-04-CMS-1450 for this medical claim. Therefore, the following Medicare payment policy found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf, section 10.7.1 – Outlier Adjustments, applies.

> "*If a claim has more than one surgical service line with a status indicator (SI) of S or T and any lines with an SI of S or T have less than $1.01 as charges,* ***charges for all S and/or T lines are summed and the charges are then divided across S and/or T lines in proportion to their APC payment rate****. The new charge amount is* ***used in place*** *of the submitted charge amount in the line-item outlier calculation*."

Procedure code 64450 has status indicator T with a **billed charge less than $1.01; therefore, all T line charges** are reallocated accordingly. The APC payment for this service of $372.76 divided by the sum of all S and T APC

payments of $6,695.55 gives an APC payment ratio for this line of 0.06, multiplied by the sum of all S and T line charges of $6,695.55, yields a new charge amount of $401.73 for the purpose of outlier calculation.

Procedure code 29888 has a claim **status indicator of T**, the APC payment for this service of $6,322.79 divided by the sum of all S and T APC payments of $6,695.55 gives an APC payment ratio for this line of 0.94, multiplied by the sum of all S and T line charges of $6,695.55, yields a new charge amount of $6,293.82 for the purpose of outlier calculation.

Payment for **outliers** is available when the following requirements outlined at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9014.pdf are met.

Code	OPPS Payment	Estimated cost of service = Total OPPS charges x 2015 Cost to charge rationale for facility	Outlier eligibility threshold = Line-item APC payment x 1.75	2015 Fixed-dollar threshold ($2,775) plus APC payment amount	Both thresholds met or exceeded?
29888	$6,293.82	$6,293.82 x 0.198 = $1,246.17	$6,293.82 x 1.75 = $11,014.19	$2,775.00 + $6,293.82 = $9,068.82	No, both thresholds not met
64450	$401.73	$401.73 x 0.198 = $79.54	$401.73 x 1.75 = $703.03	$2,775.00 + 401.73 = $3,176.73	No, both thresholds not met

While the Requestor's position is supported, based on the applicable Medicare payment policy no outlier payment is due.

3. The total allowable for the services in dispute is $12,637.16. The carrier previously paid $12,684.03. No additional payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	July 21, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.